| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155459 | A. Building<br>B. Wing | 05/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hickory Creek at New Castle | 901 N 16th Street<br>New Castle, IN 47362 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 of 2 residents reviewed for abuse. (Resident B)Findings include:An interview was conducted with Resident B on 5/26/26 at 1:16 p.m. She indicated she was abused in the facility about a month ago. Resident D touched her breasts. It happened in her room. The door was shut, and Resident D came into the room to give her candy, and Resident D grabbed Resident B's breast. Resident B felt uneasy about it. Resident B had waited a couple of days to tell, but the Executive Director (ED) knew all about it. Resident B was unsure why she waited to tell. Resident B would not talk to or even look at Resident D any longer. The investigation into the above allegation was provided by the ED on 5/27/26 at 10:45 a.m. It included the follow-up incident report, an interview with Resident D, an interview with Resident B, staff interviews with no concerns, multiple resident interviews, and documentation of 15-minute checks on Resident B beginning 4/6/26.The follow-up incident report, dated 4/11/6, indicated Resident B informed the ED that Resident D came into her room and touched her chest inappropriately on top of clothing. An investigation was initiated.The documented interview with Resident B, conducted by the ED and dated 4/6/26, indicated, [Name of Resident B] stopped this writer on 4/6/26 by nurse station and informed me that over a week ago [name of Resident D] had come into her room and they were talking and he reached out and touched her inappropriately on the breast with her clothing on. Writer asked her if she was ok and she stated yes. Writer asked her if she had told anyone she stated ?No, I don't know why I didn't.' She then stated, ?I'm ok. I just didn't like it.' Writer encouraged her to not invite others in her room and she was in agreement.The clinical record for Resident B was reviewed on 5/26/26 at 1:05 p.m. Resident B's diagnoses included, but were not limited to, major depressive disorder (serious mental health disorder) and insomnia (inability to sleep).The documented interview with Resident D, conducted by the ED and dated 4/6/26, indicated, Writer was into speak with resident and he stated, 'Yes i did touch her boob on top of clothing.' When writer asked him what happened he stated that he went into her room and gave [name of Resident B's roommate] a sucker and I then gave [name of Resident B] a sucker and when I did she stood up and gave me a hug and they were right there. I didn't mean any ill. I just brushed it. Writer then informed Resident D that was inappropriate. Resident D indicated he knew and apologized. Writer informed Resident D to not go into others' rooms. He was in agreement.An interview was conducted with Resident D in his room on 5/27/26 at 11:56 a.m. Resident D indicated he did not talk to Resident B anymore, and she did not talk to him anymore either. Resident B claimed Resident D grabbed her breast, but Resident D indicated he just touched it. Resident B came up and hugged him and wasn't wearing a bra, and had her titties in my face, and I reached out and touched one. Resident D had never done that before. Then three or four days later, Resident B told the ED that Resident D grabbed her breast. Resident D thought Resident B was just mad at him that day over an earlier interaction involving another resident. Resident B lived two doors down from him, but they did not interact anymore. The ED told Resident D to not talk to her anymore, so Resident D didn't.The clinical record for Resident D was reviewed on 5/26/26 at 1:10 p.m. Resident D's diagnoses included, but were not limited to, depression (serious mental health disorder)<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and anxiety (intense worry or fear).An interview was conducted with the ED on 5/27/26 at 12:15 p.m. She indicated she substantiated abuse for the allegation, as Resident D admitted to touching Resident B's breast. The ED had never seen anything like that out of Resident D before this. The Abuse Prohibition and Investigating policy was provided by the ED on 5/19/26 at 11:46 a.m. It indicated, It is the policy of [name of facility] to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusion. The definitions section of the policy defined abuse as, Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Abuse includes verbal, sexual, physical, and mental abuse facilitated by using technology. It defined sexual abuse as, Nonconsensual sexual contact of any type with a resident. Examples may include but not be limited to fondling, touching, rubbing, exposing, licking, kissing, gestures, sharing pornography, assault, rape, harassment, seduction, coercion, photographing a resident's rectal, genital, or breast areas, and/or exhibitionism.This citation relates to Intake 2975918. 410 IAC (Indiana Administrative Code) 3.1-27(a)(1) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview and record review, the facility failed to provide sufficient information to describe the results of an abuse investigation to the Indiana Department Of Health (IDOH) for 2 of 2 residents reviewed for abuse. (Residents B and D)Findings include:The clinical record for Resident B was reviewed on 5/26/26 at 1:05 p.m. Resident B's diagnoses included, but were not limited to, major depressive disorder (serious mood disorder) and insomnia (inability to sleep).The clinical record for Resident D was reviewed on 5/26/26 at 1:10 p.m. Resident D's diagnoses included, but were not limited to, depression (serious mood disorder) and anxiety (a feeling of fear and stress).An interview was conducted with Resident B on 5/26/26 at 1:16 p.m. She indicated she was abused in the facility about a month ago. Resident D touched her breasts. It happened in her room. The door was shut, and Resident D came into the room to give her candy, and Resident D grabbed Resident B's breast. Resident B felt uneasy about it. The Executive Director (ED) knew all about it. Resident B waited a couple of days to tell the ED about it. Resident B was unsure why she waited to tell. Resident B would not talk to or even look at Resident D any longer. The investigation into the above allegation was provided by the ED on 5/27/26 at 10:45 a.m. It included, but was not limited to, the follow-up incident report, an interview with Resident D, an interview with Resident B, and documentation of 15-minute checks on Resident B beginning 4/6/26.The documented interview with Resident B, conducted by the ED and dated 4/6/26, indicated, [Name of Resident B] stopped this writer on 4/6/26 by nurse station and informed me that over a week ago [name of Resident D] had come into her room and they were talking and he reached out and touched her inappropriately on the breast with her clothing on. Writer asked her if she was ok and she stated yes. Writer asked her if she had told anyone she stated ?No, I don't know why I didn't.' She then stated, ?I'm ok. I just didn't like it.' Writer encouraged her to not invite others in her room and she was in agreement.The documented interview with Resident D, conducted by the ED and dated 4/6/26, indicated, Writer was into speak with resident and he stated, 'Yes i did touch her boob on top of clothing.' When writer asked him what happened he stated that he went into her room and gave [name of Resident B's roommate] a sucker and I then gave [name of Resident B] a sucker and when I did she stood up and gave me a hug and they were right there. I didn't mean any ill. I just brushed it. Writer then informed Resident D that was inappropriate. Resident D indicated he knew and apologized. Writer informed Resident D to not go into others' rooms. He was in agreement.An interview was conducted with Resident D in his room on 5/27/26 at 11:56 a.m. Resident D indicated he did not talk to Resident B anymore, and she did not talk to him anymore either. Resident B claimed Resident D grabbed her breast, but Resident D indicated he just touched it. Resident B came up and hugged him and wasn't wearing a bra, and had her titties in my face, and I reached out and touched one. Resident D had never done that before. Then three or four days later, Resident B told the ED that Resident D grabbed her breast. Resident D thought Resident B was just mad at him that day over an earlier interaction involving another resident. Resident B lived two doors down from him, but they did not interact anymore. The ED told Resident D to not talk to her anymore, so Resident D didn't. Resident D's behavior care plan, dated 4/6/26, indicated he had an incident of inappropriately touching a peer. Two of the interventions were to keep him separated from the other resident during activities and meals, and for Resident D to not go into other resident's rooms uninvited. Resident D's care plan, dated 4/8/26, indicated he enjoyed passing out candy and treats to other residents. An intervention was for him to pass out candy and treats only in common areas, not to enter resident rooms.The follow-up section of the incident report, dated 4/11/26, indicated in its' entirety, Follow-up added -- 4/11/26 Staff and resident interviews completed with no concerns noted. Resident has been out of room per usual and showing no signs or symptoms of psychosocial distress. Residents are seen by psych services. Resident was educated on resident to resident interactions. The follow-up section did not indicate that Resident D admitted to touching Resident B's breast; that<br>(continued on next page) |

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| Hickory Creek at New Castle | 901 N 16th Street<br>New Castle, IN 47362 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the allegation was substantiated; that Resident D had a care plan to address him inappropriately touching Resident B with interventions to keep Resident B and D separated during meals and activities and not go into other resident rooms uninvited; or that Resident D's care plan for passing out candy was created after the incident to include passing out in common areas only.An interview was conducted with the ED on 5/27/26 at 12:15 p.m. She indicated she substantiated abuse for the allegation, as Resident D admitted to touching Resident B's breast. She was unsure why she did not put in the follow-up report that Resident D admitted to touching Resident B's breast; that the abuse was substantiated; that Resident D had a care plan to address him inappropriately touching Resident B with interventions to keep Resident B and D separated during meals and activities and not go into other resident rooms uninvited; or that Resident D's care plan for passing out candy was created after the incident to include passing out in common areas only. When the ED put staff and resident interviews conducted with no concerns in the follow-up report, she meant there were no concerns with other residents or staff, not that there were no concerns with Resident D's interview. The Abuse Prohibition and Investigating policy was provided by the ED on 5/19/26 at 11:46 a.m. The Reporting/Response section of the policy indicated, Upon completion of the investigation, which will occur within 5 working days of the reporting of an occurrence, a report of the investigation will be forwarded to the Long-Term Care Division of the Indiana State Department of Health.This citation relates to Intake 2975918. 410 IAC (Indiana Administrative Code) 3.1-28(e) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observation, interview and record review, the facility failed to implement a resident's comprehensive care plan interventions to prevent falls for 1 of 3 residents reviewed for accidents. (Resident 1) Findings include:The clinical record for Resident 1 was reviewed on 5/27/26 at 9:58 a.m. The diagnoses included, but were not limited to, osteoporosis (fragile bones), Lennox-Gastaut syndrome (rare, severe form of childhood-onset epilepsy [chronic neurological disorder characterized by recurrent, unprovoked seizures]), and anxiety (feelings of worry and tension). The Quarterly Minimum Data Set (MDS) assessment, dated 3/17/26, indicated Resident 1 was severely cognitively impaired, had no behaviors for rejecting care, had non-traumatic brain dysfunction, and was at risk for falls. During an observation on 5/26/26 at 12:46 p.m., and 5/27/26 at 11:31 a.m., and 1:36 p.m., Resident 1 was lying in bed without a helmet on their head and the bed was not in the lowest position. A progress note, dated 11/19/25 at 1:20 p.m. indicated Resident 1 had an unwitnessed fall out of their bed and included interventions that were in place, but did not include Resident 1 having a helmet on during or after the fall. During an interview with the Executive Director (ED) on 5/27/26 at 2:38 p.m., indicated they did not know if Resident 1 had their helmet when he fell out of bed on 11/9/25. A plan of care, dated 9/10/24, indicated Resident 1 was at risk for falls due to a history of falls, unsteady gait, and altered awareness of immediate physical environment. The interventions included, but were not limited to, bed in lowest position and helmet to be worn at all times, may remove for skin checks and hair washing. During an interview with Licensed Practical Nurse (LPN) 4 on 5/27/26 at 1:37 p.m., indicated they thought Resident 1 only needed their helmet on while out of bed and was unsure why it was not on while in bed or why the bed was not in the lowest position. During an interview with LPN 2 on 5/29/26 at 11:49 a.m., indicated sometimes Resident 1 would wear their helmet while in bed. During an interview with Certified Nursing Assistant (CNA) 3 on 5/29/26 at 11:49 a.m., indicated they usually would take Resident 1's helmet off when they got them into bed and put it back on when it was time to get out of bed. During an interview with the ED on 5/27/26 at 2:38 p.m., indicated Resident 1 should have had her helmet on at all times and the bed in the lowest position if that was what she was care planned for. Nursing staff was responsible to ensure that Resident 1's helmet was on and that her bed was in the lowest position. An IDT Comprehensive Care Plan Policy was provided by the ED on 5/28/26 at 9:00 a.m. It indicated .Policy:.each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented. 410 IAC (Indiana Administrative Code) 3.1-35(a) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review, the facility failed to ensure a nebulizer was stored in a bag to promote infection control measures (Resident 23), failed to ensure oxygen tubing was dated (Resident 1), and failed to ensure ear protectors were implemented as ordered by the physician (Resident 1) for 2 of 3 residents reviewed for respiratory services. Findings include: 1, The clinical record for Resident 23 was reviewed on 5/29/2026 at 11:14 AM. The medical diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). COPD (Chronic Obstructive Pulmonary Disease) is a long-term lung condition that damages and narrows your airways which makes it hard to breathe, especially when gases and mucus build up in your lungs.A quarterly Minimum Data Set Assessment, dated 3/24/2026, indicated Resident 23 was cognitively intact, received respiratory therapy for at least fifteen minutes each day, and was independent with upper body dressing without impairments to bilateral upper extremities.<br><br>A care plan, dated 8/12/2024 and last revised 3/30/2026, indicated Resident 23 was at risk for impaired gas exchange due to her COPD. The interventions included, but were not limited to, administer medications as ordered and nebulizer treatments as ordered.<br><br>A physician order, dated 12/30/2025, indicated for Resident 23 to receive nebulizer treatments three times a day routinely.<br><br>During an observation, on 5/26/2026 at 1:01 PM, the mask for Resident 23's nebulized was hanging on the side of the compression without covering.<br><br>During an observation, on 5/29/2026 at 10:50 AM, the nebulizer for Resident 23 was observed to have liquid still within the aerosol chamber.<br><br>A policy entitled, AEROSOLIZED MEDICATION THERAPY HAND HELD NEBULIZER, was provided by the Executive Direction on 5/29/2026 at 1:30 PM. The policy indicated to administer the treatment until medication in the chamber is depleted as well as to disassemble the unit and store within a bag when not in use.<br><br>2.) The clinical record for Resident 1 was reviewed on 5/27/26 at 9:58 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, heart failure, and generalized anxiety disorder.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/17/26, indicated Resident 1 was severely cognitively impaired and received oxygen therapy.<br><br>A physician's order for Resident 1, dated 4/15/25, indicated to change oxygen tubing once a day on Sunday.<br><br>A physician's order for Resident 1, dated 4/15/25, indicated ear protectors to O2 (oxygen) tubing every shift.<br><br>During an observation on 5/26/26 at 12:44 p.m., Resident 1 was lying in bed and did not have their oxygen tubing dated or ear protectors in place on their oxygen tubing.<br><br>During an observation on 5/27/26 at 11:31 a.m. and 1:36 p.m., Resident 1 was lying in bed and did not have their oxygen tubing dated or ear protectors on.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with Licensed Practical Nurse (LPN) 4 on 5/27/26 at 1:37 p.m., indicated they did not see a date on the oxygen tubing to indicate when it had been changed and did not know why Resident 1 did not have their ear protectors on.<br><br>A plan of care, dated 10/14/25, indicated Resident 1 had symptoms of decreased oxygenation (shortness of breath, decreased oxygen saturation, change in mental status) that required continuous oxygen.<br><br>During an interview with the Executive Director (ED) on 10/14/25 at 1:05 p.m., indicated it was nursing staff who were responsible to ensure that Resident 1 had their oxygen tubing dated when changed and that their ear protectors were on as ordered.<br><br>410 IAC (Indiana Administrative Code) 3.1-47(a)(6) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>Based on interview and record review, the facility failed to timely schedule an imaging appointment required for a pain specialist appointment for 1 of 2 residents reviewed for pain management. (Resident 8) Findings include:The clinical record for Resident 8 was reviewed on 5/26/26 at 2:37 p.m. The diagnoses included, but were not limited to, intervertebral disc degeneration (progressive breakdown of the rubbery cushions [discs] between the spine's vertebrae), lumbar region (lower back) with discogenic (originates from damaged discs) back pain and lower extremity pain and spinal stenosis (narrowing of the spaces within the spine, which puts pressure on the spinal cords and nerves). The quarterly Minimum Data Set (MDS) assessment, dated 4/7/26, indicated Resident 8 was cognitively intact, used a wheelchair, needed substantial/maximal assistance with sitting to stand and chair to bed transfers, and received scheduled pain medication. During an interview with Resident 8 on 5/26/26 at 1:12 p.m., Resident 8 indicated their back had been hurting really bad and they had been waiting to see the pain specialist for their back and needed a scan of their back prior to getting an appointment. Resident 8 indicated they had been waiting a long time to get the appointment for the back scan that was needed before they went to the pain specialist. Resident 8 indicated the Director of Nursing (DON) indicated the facility was waiting to hear back from the hospital for an appointment to be scheduled. A physician's order for Resident 8, dated 4/21/26, indicated to refer Resident 8 to the interventional pain and spine clinic for chronic back pain. A progress note for Resident 8, dated 4/23/26 at 10:14 a.m., indicated a message was left for the pain clinic to call the facility back regarding a referral appointment. A progress note Resident 8, dated 5/8/26 at 12:48 p.m., indicated a return call was received from pain management requesting a MRI (Magnetic Resonance Imaging) and 6 weeks of PT (Physical Therapy) prior to the initial appointment. A progress note, dated 5/12/26 at 9:42 a.m., indicated the clinical team attempted to schedule a MRI and were awaiting clinic scheduling from the hospital to respond with an appointment time. During an interview with Licensed Practical Nurse (LPN) 2 on 5/28/26 at 11:16 a.m., indicated they had called the hospital on 5/12/26 at 9:42 a.m. to schedule a MRI appointment for Resident 8 and was told they needed to get a referral (order) sent to them in order to schedule the MRI. LPN 2 indicated he notified the nurse practitioner after that and had not heard anymore about it. During an interview with the Director of Nursing (DON) on 5/28/26 at 11:10 a.m., indicated they had sent the order to central scheduling at the hospital for Resident 8 to have an MRI and was waiting to hear back from them on a time and day for the appointment. The DON indicated they had an appointment date of 6/5/26 written down on their desk calendar but it was not entered into the computer. The DON indicated she was unsure when it was scheduled because it was not entered into Resident 8's orders only on the desk calendar. The DON indicated whoever took the call for the appointment only wrote the date on the calendar and not in orders. The DON indicated they keep the appointment referral in a resident's orders to be reminded to call and make the appointment, then once the appointment was made, the order for the referral would be removed and a new order with the appointment is then put into the resident's EHR (Electronic Health Record). During an interview with Central Scheduling at the hospital on 5/28/26 at 11:32 a.m., indicated when a facility calls for a MRI appointment, they typically can get it scheduled within 1-2 days as long as they have an order. Central Scheduling indicated once the facility faxes them the information, the facility would then call to schedule an appointment and central scheduling did not call facilities back with an appointment, they have to be called in. They indicated the facility scheduled Resident 8's MRI appointment on 5/27/26. A plan of care Resident 8, dated 11/3/25, indicated Resident 8 was at risk for pain related to spinal stenosis, intervertebral disc degeneration, and discogenic back and lower extremity pain. During an interview with the Executive Director (ED) on 5/27/26 at 2:30 p.m., indicated nursing staff were responsible to ensure medical appointments were mad timely for residents. 410 IAC (Indiana Administrative Code) 3.1-37(a) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on interview and record review, the facility failed to hold a resident's medication, as ordered, when their blood pressure results were out of parameters for administration for 1 of 5 residents reviewed for unnecessary medication. (Resident 23)Findings include:The clinical record for Resident 23 was reviewed on 5/29/26 at 11:20 a.m. Resident 23's diagnosis included, but were not limited to, hypertension.The at risk for ineffective tissue perfusion care plan, revised 3/30/26, indicated the goal was for Resident 23 to maintain adequate tissue perfusion as evidenced by blood pressure within normal limits, no change in mental status, and no complaints of dizziness/lightheadedness/syncope, and edema. Two of the interventions were to administer medications as ordered and to monitor vital signs.The physician's orders for Resident 23, dated May 2026, indicated to administer one 10 mg tablet of Amlodipine (medication to treat high blood pressure) once a day, and to hold if the systolic blood pressure result was less than 100 or if the diastolic blood pressure (bottom reading of the blood pressure) result was less than 60, effective 8/20/25. They indicated to administer one 25 mg tablet of Carvedilol (medication to treat high blood pressure) twice a day, and to hold if the systolic blood pressure (the top reading of the blood pressure) result was less than 110 or if the diastolic blood pressure result was less than 60, effective 8/1/24.The May 2025, medication administration record (MAR) for Resident 23 indicated the Amlodipine was administered on the following days with the following diastolic blood pressure results: 5/4/26 at 54, 5/6/26 at 54, 5/15/26 at 59, and 5/17/26 at 54. The Carvedilol was administered at the following times and days with the following diastolic blood pressure results: morning of 5/4/26 at 54, morning of 5/6/26 at 54, morning of 5/8/26 at 58, morning of 5/9/26 at 59, morning of 5/15/26 at 59, morning of 5/17/26 at 54, evening of 5/14/26 at 50, and the evening of 5/21/26 at 57.An interview was conducted with the Director of Nursing Services (DNS) on 5/29/26 at 12:10 p.m. She reviewed Resident 23's May, 2026 MAR and indicated the Amlodipine and Carvedilol were administered to Resident 23 on the above dates when they should have been held.The General Dose Preparation and Medication Administration policy was provided by the Executive Director (ED) on 5/29/26 at 1:44 p.m. It indicated, Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 3.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.3.5 If necessary, obtain vital signs.410 IAC (Indiana Administrative Code) 3.1-48(a)(1) |